Written Comments Submitted to the Department of Health Care Services (DHCS)
Regarding the Transfer of the Drug Medi-Cal Program to DHCS, Effective July 1, 2012

Comments received July 22 through July 27, 2011

Note: In some cases, DHCS has edited the responses to explain the acronym used by the writer, or to remove personally-identifying information. Specific references to the writer's organization have not been removed.

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The California Association of Alcohol and Drug Programs Executives, Inc. (CAADPE) submits the following written comments regarding the transfer of the state's Drug Medi-Cal program from the California Department of Alcohol & Drug Programs (DADP) to the California Department of Health Services (DHCS):

DHCS and DADP's current efforts to implement Assembly Bill (AB) 106 appear to be entirely focused on the mechanics of physically moving the Drug Medi-Cal Program from DADP to DHCS. While CAADPE recognizes this is a primary and immediate necessity as part of the legislative mandate, CAADPE does not believe it is the sole mandate of the law. CAADPE believes the law expresses a much greater intent of the Legislature.

AB 106 speaks clearly to improving access to Alcohol and other Drug Treatment Services, including a focus on recovery and rehabilitation services. It also states that the transfer will improve state accountability and outcomes. These two points alone make clear that the intent of the legislation is much broader than the physical move from one department to another. To ensure improvements in the provision of Drug Medi-Cal services, stakeholders have an obligation to focus on these essential aspects of the legislation. CAADPE believes discussions addressing benefits, regulations, realignment impacts on the delivery and integration of care, and the mandated interface with health care reform must be on the agenda for early discussion.

CAADPE appreciates the acknowledgement by DADP and DHCS of the importance of involving stakeholders. In addition, CAADPE recognizes the departments' current efforts to involve stakeholders in designing the plan for the transfer of the program. The process outlined by DHCS/DADP staff to gather stakeholder input is reasonable and in accordance of legislative direction stipulated in AB 106. However, CAADPE is concerned that there has been no indication of ongoing stakeholder participation after the plan is submitted to the Legislature. CAADPE recommends DHCS establish an ongoing stakeholder workgroup to monitor and address implementation issues and to provide expert guidance and advice regarding ongoing delivery of Drug Medi-Cal services once the plan is adopted. CAADPE requests that DADP and DHCS consider the following recommendations in developing and designing the plan to transfer of the Drug Medi-Cal Program.

Stakeholder Input: CAADPE notes that DHCS has convened focus groups to solicit comments and recommendations from consumers, providers, and counties. As we look at the need for integrated care and realignment to counties of both substance use and mental health disorders services, CAADPE recommends DHCS/DADP organize an additional joint group comprised of mental health and substance use disorder providers.

Rate Setting: CAADPE supports the current policy of Drug Medi-Cal rates being set annually by the State. CAADPE opposes any proposal that would delegate to counties the authority to set rates or to alter reimbursement rates.

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Billing Process: The current billing process for Drug Medi-Cal services is cumbersome and complicated for many counties and providers, especially for direct contract providers. CAADPE recommends a review of this process with a focus on streamlining and improving efficiencies in the billing and reimbursement process.

Electronic Billing: CAADPE recognizes that standardization of electronic billing will be required under health care reform. The state, counties, and providers should be focused on designing and developing standardized billing procedures compatible with the electronic health records currently under development. This issue is an integral part of the discussions for the transfer of Drug Medi-Cal services to DHCS.

Cost Reports: CAADPE recommends that Cost Report requirements be eliminated. Currently the Drug Medi-Cal program consists of five allowable treatment services. Cost Reports are required for four of the five services that comprise the Drug Medi-Cal Program. Narcotic Treatment Programs (NTP), the largest of the programs funded through Drug Medi-Cal, are not subject to the Cost Report requirement and thus do not submit cost reports. The mainstream Medi-Cal system does not require them, nor does Medicaid does not require them. The current state requirement for Cost Reports is cumbersome, inefficient, and both burdensome and costly to providers, counties, and the state.

Direct Contracts: Providers who hold direct state contracts for Drug Medi-Cal services are very likely to be at very high risk of disruption in services and payments if the transfer from DADP to DHCS does not take into consideration their unique circumstances. A careful look at the direct contract processes is important to avoid disruption of services. Most counties, except where there are direct state contracts, function as liaisons between providers and the state and help maintain services for the majority of Drug Medi-Cal providers.

Regulations: There is a real need to review state regulation for the Drug Medi-Cal Services. Narcotic Treatment Programs (NTP's) are examples of this need. Nationwide, the federal government regulates Narcotic Treatment Programs. In addition to the federal regulations, California has over the years, added layers of additional state regulations to govern the operations of NTP's. These added state regulations appear unnecessary, can add cost to providing services, are often cumbersome, inefficient, and interfere with the delivery of appropriate treatment and health care delivery. The state's additional regulations governing the other four Drug Medi-Cal services inhibit the ability to deliver appropriate care based on proper protocols, assessment, and identified treatment needs. The state regulations make the use of medically recognized best practices impossible. Examples of such restrictions are:

- restrictions on medications which can be used and do not respond to new medications;
- limitations the frequency and type of sessions;
- requiring added drug testing which is not based on clinical need;
- requiring operating hours in excess of federal regulations which is costly; and
- allowing only the five limited services.

AB 106 requires improvements, efficiencies, cost reductions, and improvements in service outcomes as part of its legislative mandates. Streamlining processes and eliminating duplicative regulations governing the Drug Medi-Cal program are necessary and must be a part of the plan's development.

Benefits: The current five services under the Drug Medical Program are so limited in scope and so over-regulated that it is nearly impossible to deliver care based on the clinical assessments and patient needs. The limited five services are not consistent with best practices and negatively affect patient outcomes. A review of these benefits and regulations that restrict treatment is essential.

Organizational Placement and Leadership: The current proposed creation of a Behavioral Health Services Division within DHCS will limit the influence and authority of the substance use disorders (SUD) treatment community – its issue-informed public officials and community practitioners. The two fields are substantially different in scope and service delivery, in size and resources, substantially different in philosophy and approach, and substantially different in needs and population.

CAADPE recommends the creation of two separate divisions, one for Substance Use Disorders, and the other for Mental Health Disorders. A separate deputy director should lead each division. Substance Use Disorder issues would be negatively affected without separate high-level representation. While there is a clear need for integrated care, bundling of the two services will not make administrative processes easier of more effective. In fact, CAADPE believes such a merger would further hinder efforts for the SUD field to provide essential services. The SUD field is small, and historically, has been seriously over-shadowed by Mental Health and the broader health care system. Without its own division, SUD issues lose visibility, and are thus easily ignored. Subsequently, a prominent role in policy discussions that affect SUD is severely diminished. If, however, a Behavioral Health Division is created under a single deputy, there must be an Assistant Deputy for each discipline; one for Substance Use Disorders and the other for Mental Health Disorders.

Certification Process: The current Drug Medi-Cal initial application and certification process, as well as the renewal certification process, is cumbersome and inefficient. CAADPE acknowledges that the DADP is addressing this issue, but has not made the details public. Nor has the Department involved providers in the discussions regarding improvements. The DADP application and certification process differs substantially from the one used by mental health, for reasons not fully understood. CAADPE acknowledges that the mental health application and certification process is also cumbersome and inefficient. However, there is a real need for a combined certification process for a growing number of providers who deliver services to individuals diagnosed with these two co-occurring disorders.
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1. Term "behavioral health"

The term behavioral health (BH) has become synonymous with mental health (MH) in much of the literature and practitioner literature. In general the MH field does not have a problem with BH, because in many people's mind MH and BH are the same thing. I think a good argument could be made to have the Department be the Department of MH and substance use disorder (SUD). However, I don't view this as an especially important issue.

2. MH and SUD leadership.

Not surprisingly, the person who is selected for this job will determine the extent to which there will be a successful consolidation of SUD and MH services. Many of the MH leaders, believe they know everything they need to know about SUD and consider themselves to be something of experts (after all SUD are included as a "subset" of MH disorders in the fields of psychiatry and psychology). However, most of them don't know what they don't know. In my opinion, it will be very important to have a person who has actually overseen SUD services and has a real awareness of the existing system and the rapidly evolving new treatments.

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Response to client survey:

1. What Drug Medi-Cal services are the most helpful to you?

Perinatal Day Care Rehabilitative
Day Care Rehabilitative
Outpatient Drug-Free for both adults and adolescents (Minor consent Medi-cal)
Narcotic Replacement Therapy
Would like to add: Social Model Detoxification for drugs
Residential Treatment for alcohol and/or drugs (length of stay needs further definition)

2. How would you change the Drug Medi-Cal program to get better service?

The one item to place great emphasis on is to change the group size from Only accepting 4 – 10 people to 2 – at least 17 people. With all the budget Reductions, not being able to have more than 10 people in a group is ridiculous. Yes, we need to be appropriate in terms of treatment, but we need to provide The best treatment at a reasonable cost (and allowing more people in group Is the most efficient method to address efficient group size/treatment and cost effectiveness).

3. Do you have any other comments about the Drug Medi-Cal program?

Allowing more timeliness to obtain physician signature beyond 15 days would also be helpful (at least three weeks time – 21 days).

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Response to client survey:

1. What Drug Medi-Cal services are the most helpful to you?

Alcohol and drug treatment

2. How would you change the Drug Medi-Cal program to get better service?

It is very limiting in what I can receive in services! Neither my husband or I can get the residential treatment that we need; we are both relapsers that need in-house help and we need to be away from each other until we are sober.

3. Do you have any other comments about the Drug Medi-Cal program?
Good program but way too limiting on services if you really want to help people get clean.
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County response to client survey:

1. What Drug Medi-Cal services are the most helpful to you?
DMC accounts for approximately 35% of ADP funding for the County of Santa Barbara. As such, DMC is a very important funding stream and we are grateful for the program. The DMC services most helpful to us are:

a. **Counseling services that are covered by DMC, namely individual, group and Day Care Rehabilitative counseling services.**
b. […] **our State of CA ADP DMC analyst, auditor and consultant** […] **has consistently provided the County of Santa Barbara with invaluable DMC trainings, consultation and technical assistance over the years. All of our providers know Mr. Cortese by name and find him invaluable.**

2. How would you change the Drug Medi-Cal program to get better service?
We respectfully suggest and request that DMC become more user friendly for our Fiscal Services department and our providers. The County of Santa Barbara has small service providers who have neither the capacity nor the resources to spend a lot of time billing for services. With DMC, however, they do spend a lot of time on the DMC billing process, sometimes at the expense of providing treatment services and client care. Therefore, our suggestion and request would be to simplify the billing requirements and procedures and make DMC billing requirements more understandable for our providers.

3. Do you have any other comments about the Drug Medi-Cal program?
While we understand the importance of cost containment and capitation rates, DMC does not cover the cost of providing counseling services. As Substance Abuse and Mental Health Services Administration (SAMHSA) research indicates the need for more individual counseling and Intensive Outpatient Program (IOP) services, DMC covers very little individual counseling and not enough group counseling. Because of that, service providers have difficulty utilizing certain evidenced-based practices using DMC. Also, drug testing is not included in DMC, which can also be a problem. Finally, we are finding that DMC does not cover all of the eligible costs. The County of Santa Barbara receives between 90 – 92% of legitimate DMC payments. Some services fall through the gaps unpaid.

Thank you for the opportunity to provide this feedback to you. We appreciate your inquiries.